U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 12Mar2002

Case No: 2000-BLA-537

In the Matter of

EDWARD E. MORELAND
Claimant

v.

ALLEGHENY MINING CORPORATION/
NEW ALLEGHENY, INC.
Employer

WEST VIRGINIA COAL WORKERS'
PNEUMOCONIOSIS FUND
Carrier

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS
Party-in-Interest

DECISION AND ORDER ON REMAND - AWARDING BENEFITS

On October 13, 2000, I issued a Decision and Order - Denying Benefits in the above-captioned case. I found that Claimant was a coal miner for at least thirty years; that he has one dependent, his wife Ruth, for purposes of augmentation of benefits; that Allegheny Mining Corporation is the responsible operator for this claim; that the instant claim was a duplicate claim, rendering 20 C.F.R. § 725.309(d) applicable and requiring Claimant to establish a material change in conditions since the denial of his previous claim; that the previous claim was denied for failure to establish total disability due to pneumoconiosis; and that Part 718 of the Regulations applies. Applying Part 718 to the newly submitted evidence, I found that the medical opinions established total pulmonary disability, but that its relationship to pneumoconiosis was not proven. I reasoned that:

> None of the physicians specifically opined that pneumoconiosis was a substantial contributor to Claimant's disability. I accord Dr. Mathur's opinion no weight as he himself admitted that he was not qualified to render an opinion as to pulmonary disability causation. I accord greater weight to Dr. Fino's opinion because of his superior qualifications and because he took into account Claimant's significant cigarette smoking when rendering his opinion. **...** I find Dr. Fino's opinion to be well-reasoned and well-documented. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987); *Clark v. Robbins Coal Co.*, 12 B.L.R. 1-149)(en banc)(sic). Drs. DeRienzo and Mathur did not address whether cigarette smoking contributed to Claimant's disability or, in the alternative, how they ruled out cigarette smoking as a contributor to the disability, thus I accord their opinions less weight. I accord less weight to Dr. Wald's opinion because it is vague. *Griffith v. Director, OWCP*, 49 F.3d 184 (6th Cir. 1995); *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988); *Parsons v. Black Diamond Coal Co.*, 7 B.L.R. 1-236 (1984). Dr. Wald concludes that Claimant is unable to perform the duties of his last coal mine job but his opinion is not clear as to the causation of the disability.

Moreland v. Allegheny Mining Corporation, 2000-BLA-537 (Oct. 13, 2000) at pp. 11-12 (footnote omitted). Based on this finding, benefits were denied.

Claimant appealed that denial to the Benefits Review Board ("the Board"). On October 23, 2001, the Board affirmed in part, vacated in part, and remanded the claim for further consideration consistent with its opinion. The Board affirmed the findings on the length of coal mine employment, the responsible operator, and the treatment of the medical opinions of Drs. Mathur, DeRienzo and Aneja, as unchallenged on appeal. However, the Board vacated the findings concerning no material change in conditions and the medical opinions of Drs. Fino and Wald. The Board instructed that:

> [T]he administrative law judge on remand should apply the revised regulation on causation which now provides: "Pneumoconiosis is a 'substantially contributing cause' of the miner's disability if it: (i) Has a material adverse effect on the miner's respiratory or pulmonary condition; or (ii) *Materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment*." 20 C.F.R. §718.204(c)(1)(emphasis added). *See Tennessee Consolidated Coal Company v. Kirk*, 2001 WL 1012089 *6 (6th Cir.).

Moreland v. Allegheny Mining Corporation, BRB No. 01-0249 BLA (Oct. 23, 2001) at p. 5.

Material Change in Conditions

In the District Director's April 1, 1997 Decision concerning Claimant's previous claim, it is checked off that Claimant did not show that he was totally disabled due to pneumoconiosis. However, that box combines both the issues of disability and causation. The body of the decision indicates that

the Director did not find total disability based on the non-qualifying results of the pulmonary function and arterial blood gas tests. (DX 51). Therefore, as the newly submitted evidence shows that Claimant is now totally disabled, Claimant has established a material change in conditions. 20 C.F.R. § 725.309(d);[1] *Lisa Lee Mines v. Director, OWCP*, 86 F.3d 1358, 1363 (4th Cir. 1996).[2] *See Sharondale Corp. v. Ross*, 42 F.3d 993, 997-98 (6th Cir. 1994). As such, he is entitled to a de novo review of his claim for benefits.

Medical Evidence

The following is a summary of the pertinent medical evidence of record:

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[1] On January 19, 2001, substantial changes to Parts 725 and 718 of the Federal Regulations became effective. Pursuant to § 725.2(c), the revisions of Part 725 apply to the adjudication of claims that were pending on January 19, 2001, except for the following sections: § 725.309, 725.310, etc. (see the C.F.R. for the complete list of exempted sections). Therefore, the revised § 725.309(d) is not applied to this claim.

[2] Because Claimant last worked as a coal miner in the state of West Virginia, the law as interpreted by the United States Court of Appeals for the Fourth Circuit applies to this claim. *Shupe v. Director, OWCP*, 12 BLR 1-200, 1-202 (1989).

In *Lisa Lee*, the court held that under § 725.309(d), an administrative law judge must consider all of the new evidence, both favorable and unfavorable, to determine whether the miner has proven at least one of the elements of entitlement that previously was adjudicated against him. If a claimant establishes the existence of one of these elements, he will have demonstrated a material change in condition as a matter of law. Then, the administrative law judge must consider whether all the evidence of record, including evidence submitted with the prior claim, supports a finding of entitlement to benefits.

A. Chest X-rays

Ex.No.	Date of X-ray	Film Qual.	Physician/ Qualifications[3]	Interpretation
DX 50	3/6/74	-	Mock	1/1, p, all six zones.
DX 50	3/6/74	±	Browning	0/1, p, right zones.
DX 50	5/22/80	2	Cox/BCR, B	Completely negative.
DX 51	11/20/96	2	Navani/BCR, B	Completely negative.
DX 51	11/20/96	2	Francke/BCR, B	0/1, t, upper zones. A few small bullae or blebs (bu) in right upper lung.
DX 51	11/20/96	2	McMahon/BCR, B	1/1, p/s, all six zones.
DX 14, 15	8/6/98	2	McMahon/BCR, B	1/1, p/s, all six zones.
DX 16	8/6/98	2	Gaziano/B	1/0, q, all six zones.
DX 35	8/6/98	1	Spitz/BCR, B	0/1, q/t, right upper zone.

[3] The symbol "BCR" denotes a physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc. or the American Osteopathic Association. 20 C.F.R. § 727.206(b)(2).

The symbol "B" denotes a physician who was an approved "B-reader" at the time of the x-ray reading. A B-reader is a physician who has demonstrated expertise in assessing and classifying x-ray evidence of pneumoconiosis. These physicians have been approved as proficient readers by the National Institute of Occupational Safety & Health, U.S. Public Health Service pursuant to 42 C.F.R. § 37.51 (1982).

Ex.No.	Date of X-ray	Film Qual.	Physician/ Qualifications	Interpretation
DX 36	8/6/98	1	Wiot/BCR, B	0/0. Old granulomatous disease in extreme right apex and some linear stranding extending to the hilum, consistent with a past inflammatory process.
DX 37	8/6/98	1	Meyer/BCR, B	Completely negative.
DX 49	12/2/99	1	Fino/B	Completely negative.
CX 2	12/17/99	-	Wald/A	0/0.

B. Medical Opinions and CT Scan

Dr. Ragaa Fadl interviewed and examined Claimant on January 30, 1980. The smoking history was one pack a day for thirty-four years. The occupational history was twenty-three years of coal mining. Examination revealed an increased AP diameter, no expansion, and hyperresonance. An arterial blood gas test was obtained. Dr. Fadl diagnosed pulmonary emphysema due to Claimant's long exposure to coal dust. (DX 50).

Dr. Yong Dae Cho interviewed and examined Claimant on November 20, 1996 and December 12, 1996. Examination revealed scattered expiratory wheezes. An x-ray was positive for pneumoconiosis, 1/1. A pulmonary function study revealed a minimal obstructive lung defect. An additional restrictive lung defect could not be excluded by spirometry alone. An EKG showed sinus tachycardia, and an abnormal right axis deviation (QRS axis > 100). Dr. Cho diagnosed interstitial lung disease with chronic obstructive pulmonary disease ("COPD") by chest x-ray, pulmonary function study, examination, work history, and physical. He related the diagnosis to coal dust and cigarettes. Dr. Cho found a mild to moderate disability from lung disease. (DX 51).

On February 7, 1997, Dr. Cho wrote, in response to the Director's inquiry, that:

6. Diagnosis:
   Coal Worker's Pneumoconiosis
   His chest x-ray showed interstitial lung disease and the PFS showed mild obstruction. The lungs show expiratory wheezes on auscultation and he has a history of wheezes and cough.

7. Etiology:
   Coal Dust.
   His cigarette smoking is also a significant contributing factor.

8. Disability:
   Only mildly disabled. He is more likely disabled by low back pain, from his last job as a heavy equipment operator. (His last job in coal mine employment)

(DX 51).

On February 24, 1997, Dr. Cho wrote, in response to another inquiry from the Director, that "[e]ven with a negative chest x-ray he obviously has mixed chronic obstructive pulmonary disease by pulmonary function study and physical evidence of wheezing. Since his chronic obstructive pulmonary diseae (sic) is caused, in part, by his 21 years of coal mine employment, I still believe he has coal worker's pneumoconiosis." (DX 51).

Dr. Cho examined the claimant again on August 28, 1998. He noted a positive family history for tuberculosis, diabetes, cancer, and asthma. The patient history was positive for pneumonia, attacks of wheezing and allergies. Dr. Cho noted a smoking history of one pack of cigarettes per day from the 1940's until 1997. The chief complaints were daily sputum, daily wheezing, dyspnea, cough, chest pain, orthopnea, and paroxysmal nocturnal dyspnea. The chest x-ray revealed interstitial lung disease, 1/1. The pulmonary function testing revealed a minimal obstructive defect confirmed by a decrease in flow rate at peak flow at 50% and 75% of the flow volume curve. Dr. Cho indicated that an additional restrictive defect could not be excluded by spirometry alone and based on the study, a more detailed pulmonary function testing may be useful if clinically indicated. Dr. Cho diagnosed interstitial lung disease with COPD considered as pneumoconiosis based on the x-ray and pulmonary function study. He attributed the diagnosis to cigarettes and coal dust. He concluded that Claimant was not disabled by coal workers' pneumoconiosis and was able to operate heavy equipment of his last job because of minimal COPD and normal arterial blood gases. (DX 10).

In a letter dated December 15, 1998, Dr. Cho stated that Claimant was not totally disabled on a pulmonary basis. He recommended a repeat pulmonary function study since the arterial blood gas was normal and the physical exam was unremarkable. Dr. Cho opined that Claimant was able to do his last mining work as a dragline operator. (DX 12).

Dr. Umberto A. DeRienzo, Jr., one of Claimant's treating physicians, submitted a letter dated January 20, 1999. Dr. DeRienzo concluded that based on his assessment, Claimant was totally disabled due to coal workers' pneumoconiosis and unable to return to his last job as a coal miner. He stated that recent pulmonary function tests showed obstructive airways disease with significant air trapping and a FEV-1 of 59% of predicted which has been unchanged since the 1996 studies. The chest x-ray revealed scar tissue in the upper lungs and the CT scan revealed emphysematous scar

tissue, although a discoid carcinoma on the left side could not be totally excluded. Dr. DeRienzo diagnosed chronic obstructive pulmonary disease. (DX 24).

Dr. DeRienzo's treatment records from June 3, 1996 - March 2, 1999 are in the record. The records document Dr. DeRienzo's usual course of treatment as well as treatment for COPD and fibromyalgia. (DX 29).

In a report dated February 2, 1999, directed to Dr. DeRienzo, Dr. Surinder K. Aneja listed the clinical impressions as: mild chronic obstructive airway disease; mild chronic fibrosis involving both apical regions; CT scan of chest does not show any definite pulmonary nodules; and history of fibromyalgia, anxiety neurosis and possible depression. Dr. Aneja also stated in his clinical impression that Claimant's subjective symptoms of dyspnea were out of proportion to the extent of obstructive air disease and were probably caused by a combination of obstructive lung disease as well as underlying anxiety neurosis, depression and possibly fibromyalgia. He noted a past smoking history of one pack per day for many years, quitting two years ago. (DX 29).

Dr. Ajay K. Mathur's office notes dated February 19, 1999, are in the record. Dr. Mathur noted a past smoking history, quitting a few years ago. The impressions were listed as fibromyalgia, with significant pain, fatigue and tenderness all over the body in the muscles, history of chronic lung disease and anxiety and stress. Dr. Mathur concluded that by looking at his overall condition and the fact that he has not improved over the years, Claimant was not able to return to coal mine employment and seemed to be disabled. (DX 26).

In a letter dated March 29, 1999, Dr. Mathur stated that although Claimant has a history of chronic lung disease, he did not have any further comments regarding Claimant's lung disability status and deferred to the pulmonary specialist, Dr. Aneja. He explained that he specialized in rheumatology, not pulmonary medicine. Dr. Mathur stated that Claimant's generalized pain, fatigue and tenderness were consistent with the diagnosis of fibromyalgia. He explained that as he was not a pulmonary specialist, he was unable to comment on whether Claimant was disabled strictly on a pulmonary basis. Dr. Mathur stated that the generalized pain appeared to be significant which in turn prevents Claimant from working as a coal miner. (DX 28).

Claimant was evaluated at Pulmonary & Critical Care Associates, Inc., on August 5, 1999. A significant smoking history of one pack per day from age nine to age fifty-nine, quitting three years ago, was noted. The chest x-ray was more consistent with emphysema. The pulmonary function tests were consistent with moderate obstructive airflow limitation. The arterial blood gases were normal. Dr. Kucera listed the impressions as: moderate chronic obstructive pulmonary disease, most likely resulting from tobacco use; fibromyalgia; paresthesias of the upper extremities, suspect secondary to degenerative joint disease at the C spine; and syncopal episodes. Claimant was seen again on September 28, 1999. (CX 3).

Dr. James E. Adisey evaluated Claimant on August 19, 1999, for coronary artery disease on referral from Dr. Kucera. He noted a past smoking history, quitting two years ago. Dr. Adisey set forth his conclusions in a letter dated January 18, 2000. He stated that based on the CT scan, Claimant has underlying pulmonary disease. He stated that from a cardiac standpoint, Claimant has a normal ejection fraction and no evidence of significant ischemic heart disease. He explained that he did not perform formal testing to assess whether Claimant has cor pulmonale, but did not have it by the physical examination findings. (CX 4).

The CT scan of the chest was performed on October 1, 1999 at Westmoreland. The scan showed changes of emphysema, predominantly central lobular and paraseptal emphysema and predominantly involving the mid and upper lung zones. No nodularity was evident to suggest silicosis or coal workers' pneumoconiosis. There was some minimal dependent atelectasis at the lung bases. No other abnormalities were noted. (CX 1, 4).

Dr. Michael E. Wald, a board-certified internist and A reader, submitted a report dated January 5, 2000, after examining Claimant. Dr. Wald noted a smoking history of one half to one pack of cigarettes per day for forty years, quitting three years ago. The chest x-ray was normal with an ILO classification of 0/0 indicating the absence of demonstrable pneumoconiosis. The pulmonary function study showed the presence of moderately severe airways obstruction. Dr. Wald explained that the low vital capacity most probably represented associated air trapping. An electrocardiogram revaled no evidence of ischemia or chamber enlargement. Dr. Wald concluded that Claimant has obstructive airways disease related to a combination of both asthma and chronic bronchitis. His diagnosis was based on Claimant's daily productive cough and the history of acute recurring episodes of bronchospasm with resultant wheezing and shortness of breath. Dr. Wald stated that the cigarette smoking was instrumental in the development of the chronic bronchitis. He stated that the work place was also a substantial contributing factor in the development of his chronic bronchitis and the aggravation of his asthma. Dr. Wald opined that the severity of the airways obstruction was such that Claimant is disabled from returning to work in his prior employment. (CX 2, 5).

Dr. Gregory J. Fino, a board-certified pulmonologist and B reader, examined Claimant and submitted a report dated January 11, 2000. Dr. Fino noted a smoking history of one pack per day for forty-one years from 1955 until 1996, beginning periodically from the age of nine and beginning regularly from the age of nineteen. A pulmonary function study showed moderate obstruction with no bronchodilator response. Dr. Fino diagnosed chronic obstructive bronchitis due to cigarette smoking. He opined that Claimant does not suffer from an occupationally acquired pulmonary condition as a result of coal mine dust exposure because:

1. [His] reading of the chest x-ray is negative for pneumoconiosis.

2. The spirometric evaluation that has been performed shows an obstructive ventilatory abnormality based on the reduction in the FEV1/FVC ratio. This obstructive ventilatory abnormality has occurred in the absence of any interstitial abnormality. In

addition, the obstruction shows involvement in the small airways. Large airway flow is measured by the FEV1 and FEV1/FVC ratio. Small airway flow is measured by the FEF 25-75. On a proportional basis, the small airway flow is more reduced than the large airway flow. This type of finding is not consistent with a coal dust related condition but is consistent with conditions such as cigarette smoking, pulmonary emphysema, non-occupational chronic bronchitis, and asthma. Minimal obstructive lung disease has been described in working coal miners and has been called industrial bronchitis. This condition is characterized by cough and mucous production plus minimal decreases in the FEV1 in some miners. Industrial bronchitis resolves within six months of leaving the mines. Obstructive lung disease may also arise from coal workers' pneumoconiosis when significant fibrosis is present. The fibrosis results in the obstruction. In this case, although obstruction can be seen in coal workers' pneumoconiosis, the obstruction is unrelated to coal mine dust exposure.

3. The diffusing capacity values are normal. A normal diffusing capacity rules out the presence of clinically significant pulmonary fibrosis. Of course, pneumoconiosis is an example of a pulmonary fibrosis.

4. The TLC was not reduced and this rules out the presence of restrictive lung disease and significant pulmonary fibrosis.

Dr. Fino concluded that from a respiratory standpoint, Claimant does not retain the physiologic capacity to perform all of the requirements of his last coal mine job and is disabled from performing heavy labor. Dr. Fino explained that the clinical information is consistent with a smoking-related disability. He reasoned that "[e]ven if industrial bronchitis due to coal mine employment contributed to the obstruction, the loss in the FEV1 would be in the 200 cc range. If we give back to him that amount of FEV1, this man would still be disabled." Dr. Fino stated that even if he assumed Claimant has medical or legal pneumoconiosis, it did not contribute to his disability and Claimant would be disabled had he never stepped foot in the mines. (DX 49).

Dr. Wald was deposed on July 27, 2000. His testimony was consistent with his report. Dr. Wald has been treating Claimant with an aggressive bronchodilation course of therapy since January of 2000. He noted a forty to sixty pack year smoking history. Dr. Wald did not find evidence of medical coal workers' pneumoconiosis by physical examination, by measurement of restrictive disease or by radiographic interpretation. Dr. Wald stated that although the chronic bronchitis and asthma were not caused by Claimant's coal mine experience, both respiratory conditions were aggravated by coal mine dust exposure, explaining that the coal dust exposure, over a period of years, contributed to the progression of those conditions "to the functional impairment that is existing today." He stated that the etiology to Claimant's asthma was a genetic predisposition to develop asthma. He stated that the chronic bronchitis was caused by cigarette smoking. Dr. Wald stated that Claimant could not perform the duties of his last coal mine job because of his measurable functional impairment and further exposure will exacerbate his conditions. Claimant's condition has improved but he is still

disabled from returning to his prior work in the coal industry. He stated that he is diagnosing the legal coal workers' pneumoconiosis, not medical pneumoconiosis. As to Dr. Fino's statement that industrial bronchitis subsides after the exposure ceases, Dr. Wald testified that:

> If one has an occupational bronchitis, meaning a chronic bronchitis related solely to exposure to occupational irritants, then, indeed, after six months of removal from the environment there is a very good probability that the symptoms of that bronchitis will subside.
>
> That's not Mr. Moreland's case. He has chronic bronchitis related to cigarette smoking and that's never going to subside. That's a progressive disease. It's going to get worse. It's going to get worse if we keep him in a pristine environment because it has reached the stage where it is inexorably progressive.
>
> Now, I am going to try to limit the progression, or reduce the severity of the progression, with my treatment. I'm going to try to avoid him from making it worse by keeping him out of such environments as cigarette smoking and/or coal mining. But nonetheless, this is going to progress. That's the definition of that disease state.

(CX 6).

Applicable Regulations

The claimant's claim for benefits was filed on June 23, 1998 and is governed by the Part 718 Regulations.

Pursuant to § 718.101(b), the standards for the administration of clinical tests and examinations contained in subpart B "shall apply to all evidence developed by any party after January 19, 2001 in connection with a claim governed by this part [718]**...**" (emphasis added). Accordingly, since the evidence in the instant matter was developed prior to January 19, 2001, the newly enacted § 718, subpart B does not apply.

On August 9, 2001, U.S. District Court Judge Emmet Sullivan upheld the validity of the new Regulations in *National Mining Association v. Chao*, No. 00-3086 (D.D.C. Aug. 9, 2001). Accordingly, I will apply the remainder of the newly revised version of Part 718 (i.e. subparts A, C and D) that took effect on January 19, 2001 to the facts of the instant matter.

Under Part 718, a claimant must establish by a preponderance of the evidence that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. Failure to establish any of these elements precludes entitlement to benefits. *See Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-112 (1989).

Under the Act, pneumoconiosis is defined as a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b). The regulations provide four methods for finding the existence of pneumoconiosis: chest x-rays, autopsy or biopsy evidence, the presumptions in §§ 718.304, 718.305, and 718.306, and medical opinions finding the claimant has pneumoconiosis as defined in § 718.201.[4] 20 C.F.R. §§ 718.202(a)(1)-(4).

Section 718.203(b) provides a rebuttable presumption, when a miner has at least ten years of coal mine employment, that any pneumoconiosis arose from his coal mine employment. There is no such presumption linking a miner's disability to pneumoconiosis.

Pneumoconiosis and Causation

As there is no autopsy evidence or biopsy evidence in this current case and the claimant is not eligible for the enumerated presumptions, he must rely on chest x-rays and medical opinions to establish the existence of pneumoconiosis.

Under the provisions of § 718.202(a)(1), chest x-rays that have been taken and evaluated in accordance with the requirements of § 718.102 may form the basis for a finding of the existence of pneumoconiosis if classified in Category 1, 2, 3, A, B, or C under an internationally-adopted classification system. An x-ray classified as Category 0, including subcategories 0/-, 0/0 and 0/1, does not constitute evidence of pneumoconiosis. Under § 718.202(a)(1), when two or more x-ray reports are in conflict, consideration must be given to the radiological qualifications of the physicians interpreting the x-rays. The interpretations of physicians dually-qualified as board-certified radiologists and B readers may be given more weight than the interpretations of B readers. *Worhack v. Director, OWCP*, 17 B.L.R. 1-105, 1-108 (1993); *McMath v. Director, OWCP*, 12 B.L.R. 1-6, 1-8 (1988); *Sheckler v. Clinchfield Coal Co.*, 7 B.L.R. 1-128 (1984).

As summarized above, there are nine negative readings for pneumoconiosis, and four positive readings, all Category 1. Based on numbers alone, the negative interpretations outweigh the positive findings of pneumoconiosis; however, an administrative law judge is not required to defer to the numerical superiority of x-ray evidence. *Wilt v. Wolverine Mining Co.*, 14 B.L.R. 1-70 (1990). *See also Tokaricik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1984) (the judge properly assigned greater weight to the positive x-ray evidence of record, notwithstanding the fact that the majority of x-ray interpretations in the record, including all of the B-reader reports, were negative for existence of the disease).

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[4] Section 718.201 defines pneumoconiosis as a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.

Claimant's coal mine employment did not end until March 1997. Therefore, due to the additional coal dust exposure, the x-rays obtained in the 1990s are more probative than those obtained in 1974 - 1980 as to whether Claimant developed clinical pneumoconiosis during his entire employment.

In the 1990s, Claimant had four x-rays taken. The first two, taken in 1996 and 1998, had mixed readings. The latter two, taken in 1999, were both read as negative. When considering the qualifications of the readers, the dually-qualified readers rendered positive and negative readings of the 1996 and 1998 x-rays, and one B-reader read the 1998 x-ray as positive while another B-reader read a 1999 x-ray as negative. Therefore, the readings are mixed, with the unrefuted negative readings of the 1999 x-rays tipping the balance of the evidence slightly in favor of a finding that the x-rays do not establish clinical pneumoconiosis. As such, I find that pneumoconiosis is not established under § 718.202(a)(1).

Under § 718.202(a)(4), a claimant may establish the existence of pneumoconiosis, notwithstanding negative x-rays, by submitting reasoned medical opinions. This section further provides that any such finding by a physician must be based on objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examinations, and medical and work histories.

An unreasoned opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19 (1987). A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields, supra.* An opinion may be adequately documented if it is based on items such as physical examinations, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co.*, 8 B.L.R. 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 B.L.R. 1-295 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127 (1987). Indeed, whether a medical report is sufficiently documented and reasoned is for the judge as the finder of fact to decide. *Clark, supra.*

The Board affirmed my findings, as unchallenged on appeal, as to the opinions of Drs. DeRienzo, Aneja, and Mathur. While those findings were rendered under § 718.204, they are applicable here, as the issue is still the cause of Claimant's COPD.[5]

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[5] "The term 'chronic obstructive pulmonary disease' (COPD) includes three disease processes characterized by airway dysfunction: chronic bronchitis, emphysema and asthma." 65 Fed. Reg. 79,939 (Dec. 20, 2000).

Dr. Fadl, in 1980, related Claimant's emphysema to coal dust exposure. In 1999, Dr. Kucera stated that Claimant's COPD was most likely the result of tobacco use. As neither physician explained how he ruled out the other factor as an etiology, I accord both opinions little weight.

Dr. Cho, whose qualifications are not of record, examined Claimant in both 1996 and 1998. He obtained information on all of Claimant's histories, performed thorough examinations, and obtained objective studies. He clarified his conclusion on each request of the Director. Dr. Cho concluded that Claimant's COPD was due to coal dust and cigarette smoking, even in the absence of a positive x-ray. While he did not break down his diagnosis into any of the component parts of COPD,[6] I find that Dr. Cho's conclusion is nevertheless documented and well-reasoned, and adheres to the broad definition of pneumoconiosis set forth at 20 C.F.R. § 718.201.

Dr. Wald's opinion also shows that he accepts the broad statutory definition of pneumoconiosis. On rereading, I do not find his opinion to be vague, as he clearly explained that while he did not find the coal dust exposure to be the initial cause of the chronic bronchitis or asthma, he nevertheless found it to be a significant contributing and substantially aggravating factor in the progression of said conditions. Dr. Wald's opinion is documented and well-reasoned. He obtained information on all of Claimant's histories, performed a thorough examination, and obtained objective studies. At his deposition, he did not evade any of the questions, but answered them directly and thoroughly. He made clear where his and Dr. Fino's opinion are in disagreement, and the cause of that disagreement. He consistently referred to the definition of pneumoconiosis at 20 C.F.R. § 718.201, and explained how it applied here. I find Dr. Wald's testimony to be highly persuasive that Claimant's chronic bronchitis and asthma falls within the statutory definition, even though coal dust exposure was not the initiating cause of those conditions.

Dr. Fino concluded that Claimant does not have pneumoconiosis, medical or legal. He attributed all of Claimant's obstruction to cigarette smoking. However, a close examination of Dr. Fino's reasoning shows that he ruled out pneumoconiosis based on the absence of factors indicating fibrosis, or clinical pneumoconiosis, which is only half the definition found at 20 C.F.R. § 718.201. *See Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000) ("although 'fibrosis' is generally associated with 'medical' pneumoconiosis, it is not a required element of the broader concept of 'legal' pneumoconiosis"). Dr. Fino's analysis of the medical literature limiting the effects of coal dust exposure to medical pneumoconiosis and temporary industrial bronchitis has been rejected by the United States Department of Labor. 65 Fed. Reg. 79,937 - 79,945. Thus, although Dr. Fino's opinion is documented, I find that it is not well-reasoned. Accordingly, I give the opinion little weight.

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[6] The physicians are in agreement that Claimant has COPD. The opinions have been various as to whether the COPD consists of emphysema, chronic bronchitis, and/or asthma. The CT scan showed emphysema.

Weighing these opinions, I find that Claimant has established pneumoconiosis under § 718.202(a)(4). The opinions of Drs. Cho and Wald are documented and well-reasoned, and outweigh the opinion of Dr. Fino.

Weighing all of the evidence on pneumoconiosis, both like and unlike, I find that Claimant has established pneumoconiosis. Both Drs. Cho and Wald reached their conclusions despite negative x-ray readings.

Cause of Total Disability

As noted by the Board, the revisions to 20 C.F.R. § 718.204(c)(1) clarify when pneumoconiosis is a "substantially contributing cause" of disability. I find that the opinions of Drs. Cho and Wald establish that the pneumoconiosis was a substanitally contributing cause. Dr. Cho found coal dust exposure to be an equal cause with cigarette smoking of the COPD, although he did not find the COPD to be disabling. Dr. Wald found that coal dust exposure significantly contributed to the chronic bronchitis, which was initiated by cigarette smoking, and substantially aggravated the asthma, which was due to a genetic predisposition. Claimant did not become totally disabled until after the coal dust exposure ceased, so these opinions meet the standard under § 718.204(c)(1)(i), which is consistent with the finding under § 718.202(a)(4).

Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Where the evidence does not establish the month of onset, benefits begin with the month that the claim was filed. 20 C.F.R. § 725.503(b).

Claimant filed this claim in June 1998. In August 1998, Dr. Cho concluded that Claimant was not totally disabled. However, in my previous decision, I found Dr. Cho's opinion to be outweighed by the other opinions of record as to disability. Therefore, I find that Claimant is entitled to benefits beginning with the month in which he filed the claim.

Attorney's Fees

No award of attorney's fees for services to the claimant is made herein since no application has been received. Thirty days are hereby allowed to claimant's counsel for the submission of such an application. His attention is directed to (new) 20 C.F.R.§ 725.365 and § 725.366 of the Regulations. A service sheet showing that service has been made upon all parties, including the claimant, must accompany the application. Parties have ten days following receipt of such application within which to file any objections. The Act prohibits the charging of a fee in the absence of an approved application

ORDER

Employer, ALLEGHENY MINING CORPORATION, and its carrier, WEST VIRGINIA COAL WORKERS' PNEUMOCONIOSIS FUND, are hereby ORDERED to pay the following:

1. To Claimant, Edward E. Moreland, all benefits to which he is entitled under the Act, augmented by reason of his one dependent, commencing June 1, 1998; and

2. To Claimant, all medical and hospitalization benefits to which he is entitled, commencing June 1, 1998.

A
MICHAEL P. LESNIAK
Administrative Law Judge

NOTICE OF APPEAL RIGHTS. Pursuant to 20 C.F.R. Section 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this Decision and Order was filed in the office of the District Director, by filing a notice of appeal with the *Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601*. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Avenue, NW, Washington, D.C. 20210.